

# 2017 Pre-Filed Testimony Payers



## Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

**Monday, October 2, 2017, 9:00 AM**  
**Tuesday, October 3, 2017, 9:00 AM**  
**Suffolk University Law School**  
**First Floor Function Room**  
**120 Tremont Street, Boston, MA 02108**

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us), or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8<sup>th</sup> Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: [www.mass.gov/hpc](http://www.mass.gov/hpc).

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the [HPC's homepage](#) and available on the [HPC's YouTube channel](#) following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email [Andrew.Carleen@state.ma.us](mailto:Andrew.Carleen@state.ma.us) a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, [www.mass.gov/hpc](http://www.mass.gov/hpc). Materials will be posted regularly as the Hearing dates approach.

## Exhibit B: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us).

You may expect to receive the questions and exhibits as an attachment from [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us). Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us) or (617) 979-1400.

## Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us). Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

**If a question is not applicable to your organization, please indicate so in your response.**

### 1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC [presented](#) at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between \$279 to \$794 million annually.

- a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
  - i. **Priority 1:** Reduce growth in prescription drug spending
  - ii. **Priority 2:** Increase the use of alternative payment methods (APMs)
  - iii. If you selected "other," please specify: [Click here to enter text.](#)
- b. Please complete the following questions for **Priority 1** (listed above).
  - i. What is your organization doing to advance this priority and how have you been successful?

Prescription drug spending is one of the major drivers of medical expense trend. Neighborhood Health Plan (NHP) data demonstrates that specialty pharmacy prices account for over 20% of trend. Many of the more expensive drugs are currently reimbursed on the medical benefit (e.g., infused chemotherapy, intravenous immunoglobulin, and drugs for inflammatory conditions) where it is more difficult for a health plan to control pricing.

NHP has adopted a web-based prior authorization and site of care delivery tool which is helpful in the cost control effort as it standardizes the medical benefit with pharmacy benefit pricing. In addition, this approach allows the health plan to enforce prior authorization criteria to ensure that these expensive drugs are only used for evidence-based indications. Thirdly, this approach provides an opportunity to direct treatment to the most efficient site of care. For example, a member may receive an infusion in the home instead of a more expensive hospital-based infusion center. Although this project was just launched this month, initial experience indicates that there will be significant savings associated with both the prior authorization and site-of-service components.

In addition to the specialty drug management approach outlined above, NHP continues to ensure effective review of new-to-market drugs through our Pharmacy and Therapeutics Committee which confirms safety and efficacy of prescription drugs. Lastly, NHP continues to employ prior authorization requirements, step-therapy, and quantity limitations to control wasteful prescription drug expenditures.

- ii. What barriers does your organization face in advancing this priority?

The major barrier to mitigation of pharmacy costs is the lack of transparency in drug pricing. Many pharmaceutical companies continue to price their products to maximize profits without consideration of the added value of new medications adding significantly to overall trend.

- iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

To address this barrier, the Commonwealth should consider convening a multi-stakeholder group that evaluates best practices related to the comparative effectiveness of new drugs based on defined prioritization process (e.g., high demand or utilization). This information could then be utilized by health plans or the Commonwealth to better inform their coverage or formulary decision process and address cost containment.

- c. Please complete the following questions for **Priority 2** (listed above).

- i. What is your organization doing to advance this priority and how have you been successful?

A strategy NHP is using to increase the use of APMs has been contracting with providers at the delivery system and/or Physician-Hospital Organization (PHO) level. This key first step brings all primary care providers, specialists and hospital(s) under one agreement and brings all NHP members together serving to increase the number of members participating under an APM. This system-focused contracting approach also leverages infrastructure at the delivery system/PHO to assist in creating targeted programs, provide data sharing and measure outcomes in support of managing total medical expense. Under these new arrangements, NHP will work to incorporate the APM structure utilized in other arrangements and enhance APM components based on current experience. As part of the recent MassHealth restructuring effort, NHP is partnering with Merrimack Valley ACO under the MassHealth ACO program. The infrastructure being implemented for this program will be utilized to expand to commercial/QHP populations in the future as well to support other APM arrangements.

- ii. What barriers is your organization facing in advancing this priority?

As noted in the past, it is important to fully understand a provider's readiness and ability to effectively participate in an APM. Not all providers have access to the same level of infrastructure needed to support the requirements of an APM arrangement (e.g., IT infrastructure, reporting capabilities, and other administrative tasks relates to financial and clinical outcome analysis). Providers have expressed a strong preference for standardization of performance measurement across all payers. NHP has advocated for a level of standardization regarding quality measures drawn from the Massachusetts Standard Quality Measure Set, but there remains a certain level of customization in the marketplace which can be a barrier to the provider's effort to make data-driven decisions to support a risk contract.

NHP has a relatively small membership pool within the overall marketplace. In fact, our membership with many providers has been too small to support the scale necessary under a risk arrangement. This issue has been exacerbated relative to the changing health care landscape in Massachusetts. As NHP experiences membership shifts in many cases, membership levels may not be sufficient to support APMs. NHP will monitor membership levels and introduce APM components as our membership increases in key provider groups. NHP will also use this time to incorporate limited components in the form of quality measures and shared shavings models with our network. As membership growth expands, NHP will adjust these APM offerings to coincide with provider risk-sharing arrangements.

- iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

The state legislature, the Health Policy Commission (HPC) and other state agencies should continue efforts to create incentives for those providers to participate in an APM arrangement. Possible options include either competitive grants, technical assistance, incentives for collaboration among small providers, etc. Setting the proper incentive to incent participation, in concert with ongoing health plan efforts to increase the use of APMs, will advance this priority and lead to more efficient care delivery.

## 2. STRATEGIES TO IMPROVE CLINICAL DATA COLLECTION

In each of its four annual reports, the HPC has called for the improvement and alignment of quality measures, particularly for the measures used in APM contracts, and has recognized the burden of reporting different quality measures for different purposes. Please answer the following questions regarding how your organization collects clinical quality data.

- a. How does your organization currently collect clinical data from contracted provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process? [check all that apply and explain the purpose for which you collect the data for each] **Required Answer.**
- ☒ Excel document or equivalent  
*Purpose:* NHP currently collects certain data (e.g. postpartum visit date, type of provider, etc.) in an excel spreadsheet format for our APM contracts. This data is then combined with claims data to create rates which are used in the calculation of the quality score which determines the provider payout based on quality performance. The quality measures are HEDIS measures.
  - ☒ Direct data feed  
*Purpose:* NHP has established a direct transfer process with certain provider organizations. This data is being collected for some APM partners as well as non-APM partners that are large providers in our network. In both cases, the data is used to help in the HEDIS data collection process. This added data transfer reduces the burden of reviewing medical record charts during the HEDIS process. NHP receives this data in standard Health Level-7 format from some providers and custom data from other APM providers.
  - ☒ Chart reviews by third-party vendor  
*Purpose:* We currently hire temporary RN-level nurse providers who collect medical record chart data related to HEDIS efforts. This data is used to build the HEDIS rates.
  - ☐ Web-based portal  
*Purpose:* Click here to enter text.
  - ☐ Other: Click here to enter text.  
*Purpose:* Click here to enter text.
- b. How frequently do you collect clinical quality data from contracted providers? **Required Answer.**
- ☒ Ongoing
  - ☒ Monthly
  - ☐ Quarterly
  - ☒ Annually
  - ☐ Other: Click here to enter text.

- c. What is the estimated cost of staff and resources to collect and report on provider clinical quality data each year?
- Estimated cost (in dollars): \$1.5M
  - Estimated FTEs: 5 FTEs

### 3. STRATEGIES TO ADDRESS DRUG SPENDING

The HPC, other state agencies, payers, providers and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. In its 2016 Annual Cost Trends report, the HPC highlighted a range of strategies to reduce drug spending increases, including value-based contracting.

- a. Are you pursuing value-based drug contracting? **Required Answer.**

☐ Yes ☒ No

If yes, with whom?

**Required Answer:** [Click here to enter text.](#)

- b. If yes, have you found that your value-based contracts have resulted in meaningful cost savings and/or quality improvement? **Required Answer**

- ☐ Yes, cost-savings only  
☐ Yes, quality improvement only  
☐ Yes, both  
☐ No  
☐ Unknown (insufficient time to measure improvement)

- c. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply.

**Required Answer.**

- ☐ Lack of appropriate quality measures  
☐ Administrative and operational implementation costs  
☐ Inability to negotiate performance incentives with manufacturers  
☒ Other (please specify): While we understand its merits, NHP does not have confidence that value-based contracting is an effective strategy to address prescription drug cost trend. Without transparency in drug pricing, pharmaceutical companies can simply adjust charges to maximize their profits corresponding to the expected outcomes. Additionally, value-based contracting has limitations regarding the group of drugs that might yield appropriate savings. Often, there are measurement challenges due to the absence of data used to determine whether the drug's price was appropriate compared to its relative value. It should be noted that many well publicized value-based contracts have been limited in scale as many prescription drug manufacturers have not been inclined to engage in value-based contracts where there is no direct competition.

### 4. STRATEGIES TO SUPPORT INNOVATIVE CARE DELIVERY THROUGH PAYMENT POLICIES

Public payers are implementing new payment policies to support the development and scaling of innovative, high-quality and efficient care delivery, such as, for example, Medicare's readmissions penalty for acute care hospitals, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, and MassHealth's new flexible services spending allocation in its new ACO program to address patients' non-medical needs.

- a. Has your organization adopted any new payment policies related to the following areas of care delivery improvement and innovation? [check all that apply] **Required Answer.**

- ☒ Readmissions  
☒ Avoidable ED visits  
☒ Serious reportable events  
☒ Behavioral health integration into primary care (e.g. collaborative care model)

- ☒ Care management (e.g., serious or chronic illnesses)
- ☒ Telehealth/telemedicine
- ☐ Non-medical transportation
- ☒ Services to maintain safe and healthy living environment
- ☒ Physical activity and nutrition services
- ☒ Services to remove/protect patients from violence
- ☐ Other: [Click here to enter text.](#)

- b. For each area identified above, please describe the payment policy in more detail, including whether it is a payment penalty or non-payment, fee-for-service reimbursement for new service codes, per-member-per-month fee, etc.

**Readmissions:**

NHP has contracted with a large provider organization on a full-risk basis. Because of this arrangement, NHP has incentivized the provider group to implement care management activities that mitigate the risk of readmissions. NHP supports this work by providing data that is member-specific. NHP provides cost and utilization data monthly to the provider group. This data can be used to identify members who are at risk of readmission based on utilization patterns (e.g., high emergency department usage; poor medication compliance) and activate effective care management.

In addition, NHP case managers contact all members who are recently discharged from an acute hospital admission to facilitate transitions of care. Services are provided in coordination with the primary care provider to arrange prescribed post-discharge care and reduce re-admission risk.

**Avoidable ED Use:**

NHP has contracted with a large provider organization on a full-risk basis. Because of this arrangement, NHP has incentivized the provider group to implement care management activities that mitigate inappropriate emergency department (ED) use. NHP supports this work by providing data that demonstrates provider variation in ED utilization and member-specific data to identify frequent users of the ED. NHP provides cost and utilization data monthly to the provider group. This data is examined to identify members who have high ED visit rates and are candidates for care management. The data can also identify individual providers or a provider practice that has members with high utilization rates which may be related to limited primary care access or suboptimal use of urgent care centers. In addition, NHP has shared savings arrangements with 23 sites that include ED utilization as a metric. For these providers, NHP produces a dashboard that identifies patients seen in the ED and provides information related to diagnosis; the level of ED care; and the frequency of ED visits over the previous 12 months. NHP also provides monthly data that allows practices to track progress toward their ED utilization goals. Providers can retain savings related to decreased utilization if they perform well on a set of quality metrics, including ED utilization.

NHP also publishes additional ED reporting that is accessible on our provider portal by all primary care practices and can be used at the practice level to intervene with patients with excessive or unnecessary ED visits.

**Serious reportable events:**

NHP is applying the Centers for Medicare and Medicaid Services (CMS) requirements around non-payment for serious reportable events and are actively reviewing claims to identify these cases and recoup the appropriate dollars.

**Behavioral health integration into primary care (e.g. collaborative care model):**

The full-risk contract noted above also enables NHP to support embedded behavioral health (BH) clinicians in primary care sites. In addition, NHP launched the *Here-For-You* program in 2016. *Here-For-You* identifies NHP members with significant mental illness and provides capitated payments to BH providers to better manage this population. NHP is currently analyzing the preliminary results of this program.

**Care management (e.g. serious or chronic illnesses):**

NHP also implemented the *Neighborhood Health Care Circle* (NCC) program in 2016. This program identifies the top 0.5% most costly members. Interventions include intensive case management with RNs, social workers, community health workers and BH clinicians. NCC clinicians are frequently in the community and in direct contact with members. For example, NCC clinicians are empowered to fund non-medical expenses to improve the health and welfare of the member which may include free cell phones, food, and/or medical transportation for this population.

**Telehealth/telemedicine:**

NHP is planning a two-pronged approach to provide our commercial members with access to telemedicine. The first prong, available as of July 1, 2017 in conjunction with Teladoc, offers access to convenient, low-acuity urgent care (24 hours a day, 7 days a week) from anywhere in the US. This telemedicine benefit is designed to help members gain access to affordable (same cost as a primary care provider, or PCP visit) virtual visits, by computer, tablet or smartphone, staffed by board certified physicians from the comfort of their home or when traveling outside of Massachusetts. Members have the option of requesting an immediate consult or scheduling a visit time. NHP views this initiative as a key cost-effective alternative to ED or urgent care visits for our members, when appropriate, that also helps complement efforts to offer convenient access to care.

Secondly, as of September 1, 2017, NHP will allow network providers to deliver care to their patients via telemedicine utilizing industry standard privacy, security, coding and payment guidelines. Both PCPs and specialists can provide a wide range of services to members through this technology. From a member perspective, the cost of a virtual visit will be the same as an in-person visit.

**Non-medical transportation:**

[Click here to enter text.](#)

**Services to maintain safe and healthy living environment:**

NHP care management and the NCC program work together to provide support for social determinants of health. NCC includes community health workers who visit members in their homes, in shelters and in the community, if homeless. The NCC program, as well as our complex telephonic care management programs, utilize comprehensive assessments that evaluate members' bio-psycho-social needs. Our comprehensive social assessments evaluate current living conditions including concerns with the physical environment, (e.g., risk for falls, fire safety as well as mobility status). In addition, the social assessment evaluates the status of public utilities access (such as risk for shut off, arrear in payments, heating needs, participation in discount programs).

The NCC program, in combination with our complex telephonic programs, address determined issues in a variety of ways including referrals for community based services, communication with providers about potential needs for durable medical equipment (DME), homecare, etc. The NCC program includes a home visiting rehabilitation specialist (licensed physical therapist) who will enter the home to evaluate member needs and communicate findings/recommendations to the care management team. Member interventions are then implemented based on the member benefit and other leveraged community resources. The NCC rehabilitation specialist will also educate members on proper use of DME, exercise, and helpful advice to make a safe and healthy home environment.

**Physical activity and nutrition services:**

The comprehensive assessments utilized by the both the NCC Program and the complex telephonic care management programs evaluate members' current physical activity (including any limitations or difficulties) and special diets that might have been prescribed/recommended by a provider. The social assessment further evaluates food insecurity and need for resources. The NCC program, as mentioned above, includes a rehabilitation specialist that will evaluate a member's conditions and limitations regarding physical activity - doing so in the home when necessary.

NCC also provides meals to members who are not able to adequately afford or prepare nutritious food. The NCC program employs a Registered Dietician who works with members to identify needs related to nutrition (such as obesity, diabetes) and helps members to achieve nutritional goals. The NCC program Registered Dietician further evaluates members for medically tailored meals provided by *Community Servings* to help to achieve goals that will reduce exacerbation of disease symptoms that often lead to hospitalization and other acute services. The NCC and care management team works together to achieve optimal health outcomes and reduce barriers, such as limited finances to afford food.

**Services to remove/protect patients from violence:**

The NCC team (e.g., BH case managers and social care managers) and the complex telephonic care management programs assist members facing a range of social issues, including violence. NHP social care managers assist to eliminate barriers to getting members the services and care they need regarding domestic violence. The comprehensive assessments used the by the NCC Program and the complex telephonic care management programs assess a members' exposure to domestic violence. If signs are present, the care manager will immediately offer resources for domestic violence which can include assistance with access to hotlines, domestic violence shelters, BH services, and other educational resources.

**Other:**

[Click here to enter text.](#)

**5. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY**

Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool."

- a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2016-2017			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2016	Q1	5382	96
	Q2	4495	101
	Q3	2765	84
	Q4	2750	68
CY2017	Q1	3412	126
	Q2	2101	106

	<b>TOTAL:</b>	20905	581
--	---------------	-------	-----

## 6. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2014 to CY2016 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2014 to 2016, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

In each of 2014 and 2016, approximately 25% of the actual observed allowed claims trend is due to benefit changes. This impact is reflected in the utilization and service mix categories of "HPC Payer Exhibit 1" which is attached. Changes in the health status or population demographics are minimal for these years.

However, in 2015 NHP experienced significant growth in subsidized non-group membership. On average, these members incur significantly higher claims than NHP's other commercial markets. This influx of subsidized non-group membership resulted in a change in the average health status of NHP's population and drove 2/3 of the overall 2015 trends. This impact is reflected in each of the unit cost, utilization, and service mix categories of "HPC Payer Exhibit 1". Aside from this population mix impact in 2015, changes to benefits or demographics had minimal impact on 2015 trend.

## 7. INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND APMs

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2016 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2018. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

- a. Please answer the following questions related to risk contracts spending for the 2016 calendar year, or, if not available for 2016, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
  - i. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
 

HMO/POS	99.66%
PPO/Indemnity Business	0.34%
  - ii. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?
 

HMO/POS	50%
PPO/Indemnity Business	0%
- b. Please answer the following questions regarding APM expansion.
  - i. How is your organization increasing the use of APMs? Are you expanding the participation in risk contracts to providers other than primary care providers (e.g., hospitals, specialists, behavioral health providers) or into new product types (e.g., PPO)?

As noted above, NHP is increasing the use of APMs in its contracting efforts with providers with a focus to engage at the delivery system and/or PHO level. This first step brings all primary care providers, specialists, and hospital(s) under one agreement. This approach also brings all NHP

members together to increase the number of members participating under an APM. It preferred for the ability to leverage infrastructure at the delivery system/PHO which assists in creating targeted programs, provide data sharing, and measure outcomes all in support of managing total medical expense. Under these new arrangements, NHP will work to incorporate the APM structure in use in other arrangements and enhance APM components based on current experience.

As part of the recent MassHealth restructuring effort, NHP is partnering with Merrimack Valley ACO under the MassHealth ACO program. The infrastructure being implemented for this program will be utilized to expand to commercial/QHP populations in the future as well to support other APM arrangements.

During the 2016 Cost Trends process, NHP outlined several behavioral health initiatives undertaken in concert with our longstanding behavioral health partner, Beacon Health Options. Building on these efforts, we have recently implemented a new bundled payment for substance use treatment (Medication Assisted Treatment bundled with Individual/Group Therapy) with a provider for Medicaid members and we are working to implement with commercial/QHP members.

- ii. What are the top barriers you are facing and what are you doing to address such barriers?

As noted in our above response to 1(c)ii, it is important to fully understand a provider's readiness and ability to effectively participate in an APM. Not all providers have access to the same level of sophistication needed to support the requirements of an APM arrangement (e.g., IT infrastructure, reporting capabilities, and other administrative tasks relates to financial and clinical outcome analysis). Providers have expressed a strong preference for standardization of performance measurement across all payers. NHP has advocated for a level of standardization regarding quality measures drawn from the Massachusetts Standard Quality Measure Set, but there remains a certain level of customization in the marketplace which can be a barrier in the provider's effort to make data-driven decisions to support a risk contract.

NHP has a relatively small membership pool within the overall marketplace. In fact, our membership with many providers has been too small to support the scale necessary under a risk arrangement. This issue has been exacerbated relative to the changing health care landscape in Massachusetts. As NHP experiences membership loss in the Medicaid population in view of the shift to ACOs, membership levels may not be sufficient to support APMs. NHP will monitor membership levels and introduce APM components as our commercial membership increases. NHP will also use this time to incorporate limited components in the form of quality measures and shared shavings models. As membership growth expands, NHP will adjust these APM offerings to coincide with risk-sharing arrangements.

- iii. Currently, most APM contracts pay providers on a FFS basis with reconciliation at the end of the year. Is your organization taking steps to move payment toward population-based models (e.g. capitation) and away from FFS as the basis for the APM contracts?

☒ Yes      ☐ No

NHP currently has one agreement under a non-FFS model and will continue to take steps to expand the move toward population-based models in new and existing APM contracts.

If no, why not? [Click here to enter text.](#)